

Energy Source Fitness Center

Membership Application

Name (Last, First, M.I.):		Date: / /
Division Routing Symbol:	Work Phone:	Date of Birth: / /
		Sex: M / F
Email Address:		Cell Phone:
Home Address:		Home Phone:
Emergency Contact:	Relationship to Member:	Emergency Contact Phone Number (s): H. W.

Membership Type

Membership Type	Employed with:
<input type="checkbox"/> VA Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree <input type="checkbox"/> Other _____	<input type="checkbox"/> ROIC <input type="checkbox"/> ITC <input type="checkbox"/> MSN <input type="checkbox"/> SSA <input type="checkbox"/> GSA <input type="checkbox"/> Other _____
Staff Notes:	
<input type="checkbox"/> Membership File <input type="checkbox"/> Medical Clearance <input type="checkbox"/> Lifetime Payment: _____ Date _____ Receipt Number <input type="checkbox"/> Monthly Payment	

New Member Interest Survey

- | | |
|---|---|
| <input type="checkbox"/> Complimentary Fitness Assessment
<input type="checkbox"/> Complimentary Functional Assessment
<input type="checkbox"/> Complimentary Equipment Orientation
<input type="checkbox"/> Complimentary Personalized Exercise Program
<input type="checkbox"/> Group Exercise – including yoga and Pilates
<input type="checkbox"/> Sport Conditioning / Sport Performance Program
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Running Group
<input type="checkbox"/> Walking Group
<input type="checkbox"/> Self Defense/Martial Arts
<input type="checkbox"/> Weight Management Programs
<input type="checkbox"/> Goal Setting Session
<input type="checkbox"/> Body Composition Screening |
|---|---|

All personal information will be kept confidential.

Facility Rules and Regulations

FITNESS CENTER ACCESS

Each member must sign in every time they use the facility.

HOURS OF OPERATION

The fitness center is open and staffed 7:00 am – 6:30 pm, Monday through Friday, excluding Federal holidays and official closures.

HEALTH AND SAFETY

You must immediately notify a fitness center staff if you experience any unusual/abnormal physical sensations or symptoms, either before, during or after exercise.

VISITORS

Only fitness center members may use the facility. Visitors must check in at the front desk prior to entering the facility.

FOOD AND BEVERAGES

Food and beverages are not allowed in the locker rooms or exercise rooms. Plastic bottles containing water and sports drinks are permitted. No glass bottles or containers are permitted in the fitness center.

ATTIRE

Shirts are required and appropriate footwear must be worn at all times while using the fitness center.

LOCKERS

Day lockers are available for use during each exercise session. Day lockers must be cleaned out at the end of the exercise period and may not be used for storing items except during workouts. Individuals are responsible for providing a lock to secure personal belongings. The Energy Source Fitness Center and L&T Health and Fitness are not responsible for items lost, stolen, or damaged while stored in lockers or in the facility.

EXERCISE ROOM/EQUIPMENT

- ♦ Any equipment malfunctions or breakdowns should be reported immediately to the fitness center staff. Please do not use equipment marked "Out of Order."
- ♦ Do not drop free weights on the floor. Always return weights to their proper racks.
- ♦ In consideration of subsequent users, please wipe perspiration off the equipment. Paper towels and disinfectant spray are provided throughout the facility for this purpose.

I certify that I have read the Energy Source Fitness Center Rules and Regulations and will comply with the rules and regulations listed above.

Signature: _____

Date: _____

Witness: _____

Date: _____

Pre-Participation Screening Questionnaire

Please complete this form to help us determine your readiness to begin a physical activity program. Information that you provide on this form will be maintained in a confidential manner and disclosed only to fitness center staff, unless required by law. With your authorization, it may also be provided to your physician(s) should your answers indicate physician's recommendations are necessary. This information will be used only for the purposes of your participation in the fitness center.

Name (Last, First, M.I.): _____	Date: _____ / _____ / _____
Date of Birth: _____ / _____ / _____	Age: _____ Sex: M / F

Please complete this form to the best of your knowledge.

	Y	N	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a heart attack, stroke, or heart surgery? Please specify _____
2.	<input type="checkbox"/>	<input type="checkbox"/>	Has your doctor said that you have cardiovascular, pulmonary, metabolic or other significant disease?
3.	<input type="checkbox"/>	<input type="checkbox"/>	During or right after exercise, do you have pains or pressure in the left or mid-chest area, left neck, shoulder or arm?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Have you experienced leg pain upon exertion?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Has your doctor said that you have a heart murmur or irregular heart beat?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have insulin-dependant diabetes or take medication to control your blood sugar?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience shortness of breath at rest or with mild exertion?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Has your doctor said you have high blood pressure ($\geq 140/90$) or are you on medication for your blood pressure?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience dizziness/fainting spells at rest or with exertion?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently pregnant or within six weeks postpartum? (# of months pregnant _____)
11.	<input type="checkbox"/>	<input type="checkbox"/>	Are you are currently taking prescription medication for an underlying disorder (i.e., heart, lung, GI, blood) that may impact your ability to exercise? If yes, please complete the Medication Information section on the reverse side.
12.	<input type="checkbox"/>	<input type="checkbox"/>	Has your doctor said you have a muscle, bone or joint problem that could be made worse by physical activity (i.e., bursitis, arthritis, joint or muscle disorder, etc.)? Please specify _____
13.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a medical condition not mentioned here <i>which might affect your ability to participate in an exercise program</i> (i.e., seizures, emphysema, asthma, etc.)? Please specify _____

	Y	N	
14.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a male family member (father/brother) under the age of 55 OR a female family member (mother/sister) under the age of 65 who has a history of cardiovascular disease, such as heart disease, stroke, angina (chest pain), high blood pressure, etc.? Please specify _____
15.	<input type="checkbox"/>	<input type="checkbox"/>	Are you a male over the age of 45?
16.	<input type="checkbox"/>	<input type="checkbox"/>	Are you a female over the age of 55, or post menopausal, or have you had a hysterectomy?
17.	<input type="checkbox"/>	<input type="checkbox"/>	Do you consider yourself to be more than 20 lbs. overweight?
18.	<input type="checkbox"/>	<input type="checkbox"/>	Is your total serum cholesterol >200 mg/dl?
19.	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or have you smoked within the last 6 months?
20.	<input type="checkbox"/>	<input type="checkbox"/>	Are you physically inactive (i.e., you accumulate less than 30 minutes of physical activity on at least 3 days per week at work or during recreational pursuits)?

When was your last physical exam? _____

Do you have any exercise limitations not previously discussed (i.e., recent injuries, etc.)? ☐ Yes ☐ No

If yes, please explain: _____

Please list any other pertinent health/medical information (including medications): _____

I understand that the completion of this form will not result in any type of diagnosis of disease and that it is not intended as a substitute for consultation with my personal physician. I must consult my own personal physician for any evaluation of my health status.

I hereby certify that I have read and understand all questions on this health and exercise history questionnaire, and that all questions have been answered truthfully to the best of my knowledge. I agree to notify the fitness center staff if there are any changes in the information that I have provided herein.

Signature: _____ Date: _____

Witness: _____ Date: _____

Informed Consent and Waiver

All personal information will be kept confidential.

If you elect to use the Energy Source Fitness Center or if you elect to participate in any related programs, your use and participation will be at your sole risk. You should consult with your personal physician throughout your participation in the program. Liebenow & Torok, Inc., d/b/a L&T Health and Fitness (L&T), staff are trained in fitness program management but are not medically trained. Although L&T staff will assist you in learning to use the exercise equipment and in developing an exercise program, and may also conduct fitness assessments upon your request, you should not view their assistance, or the results of any fitness assessments, as a medical diagnosis or statement about your health or the suitability of a program for you.

Even consultation with your physician and engaging in regular exercise in no way guarantees against the possibility of adverse occurrences during exercise sessions, use of equipment, or related activities. Possible risks include, but are not limited to, transient dizziness, fainting, muscle cramping, musculoskeletal injury, sprains and strains, heart attack, stroke or sudden death. Please contact your physician for further details.

In consideration for being permitted access to and use of the Energy Source Fitness Center, I, my family, heirs, executors, representatives, administrators, and assigns do hereby waive, release, and forever discharge the Energy Source Fitness Center and L&T and their respective affiliates, officers, directors, employees, contractors and agents from any and all responsibilities, liabilities and lawsuits, present or future, and causes of action for ordinary negligence, whether foreseeable or unforeseeable, arising out of or related in any manner directly or indirectly, to my use of or access to the Energy Source Fitness Center, including, but not limited to, such claims that may result from any injury, illness, or death, accidental or otherwise, during or arising in any way from my participation in any exercise, health promotion or recreation activity or fitness testing associated with the Energy Source Fitness Center, or my using any of the facilities, equipment or programs made available in the fitness center. I hereby agree to expressly assume and accept sole responsibility for the risk of injury or death as long as they are not the result of gross negligence by Energy Source Fitness Center or L&T.

I understand that the screenings and programs provided or sponsored by Energy Source Fitness Center and L&T, or their respective contractors or subcontractors, do not provide a diagnosis of disease or a lack thereof and are not a substitution for regular medical care and consultation, and in no way declare my fitness or lack thereof for use of the Energy Source Fitness Center or the equipment and programs provided therein.

The undersigned hereby expressly agrees that this Informed Consent and Waiver is intended to be as broad and inclusive as permitted by the laws of the state of Pennsylvania, and that if any portion hereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I certify that I have read the above Informed Consent and Waiver and have had any questions answered to my satisfaction.

Signature: _____

Date: _____

Witness: _____

Date: _____

Title 5 U.S.C. x 7901 authorizes the head of the agency of the Government of the United States to establish, within the limits of appropriations available, a health service program to promote and maintain the physical and mental fitness of employees under his jurisdiction. The principal purpose for which the information you furnish is intended to be used is to enable Fitness Center staff to track Fitness Center membership and fee payments and to inform itself of the physical fitness of members. No routine use disclosures have been established for these records. The records and information obtained in these records will not be disclosed outside the Energy Source Fitness Center unless mandated by law. See statutory conditions of disclosure a 5 U.S.C. x 552a (b) You are not required by law to provide the above information, but failure to provide all of the requested information may result in the denial of your application.